

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-009717

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 278

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

|   |   |  |   |  |   |
|---|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |   | <b>FILED FEB 19 1963</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Lemay</b>   |   | Length of stay in 1b<br><b>3 years</b>   |   | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Lemay Nursing Home</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location)<br><b>4335 No. 19th St.</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>JOSEPH</b> Middle <b>MITCHELL</b> Last <b>BLUE</b>   |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>24</b> Year <b>1963</b> |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>              | 8. DATE OF BIRTH<br><b>May 3, 1885</b>                                  | 9. AGE (last birthday)<br><b>77 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Self</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Newburg, Missouri</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |   | 13a. FATHER'S NAME<br><b>Joseph H. Blue</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Julia Spradling</b>  |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Julia Paulson Blue</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mrs. Mabel Siekmann, 5539 Arthur Ave. 9</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>                                   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>   |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c)  |   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Generalized Arteriosclerosis</b> |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |  |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |   |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  | 20f. CITY, TOWN, OR LOCATION  |  | COUNTY  | STATE  |   |
| 21. I attended the deceased from <b>Dec. 20, 1959</b> and last saw <sup>her</sup> him alive on <b>Jan. 20, 1963</b><br>Death occurred at <b>10:15 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |  |   |  |   |
| 22a. SIGNATURE<br><b>Robert D. Sanders, M.D.</b> (Degree or title)  |   | 22b. ADDRESS<br><b>1502 Cass Av</b>  |   | 22c. DATE SIGNED<br><b>1-25-63</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>Jan. 28, 1963</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Bethlehem Cemetery</b>  |   | 23d. LOCATION (City, town, or county)<br><b>St. Louis County, Missouri.</b> (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>Beiderwieden F.H.Inc., 1936 St. Louis (6)</b> ADDRESS  |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-25-63</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>John B. Murphy M.D.</b>  |   |

Dr. Robert D. Hamilton  
1502 Cass Avenue  
9 a.m. to 5 p.m.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer.

Signed Horner W. Fritz

Licensed Embalmer No. 3882

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.